APPENDIX C

PRE-ADMISSION SCREENING INFORMATION

PRE-ADMISSION SCREENING INFORMATION

PROGRAM BACKGROUND – LEGAL BASIS

Pre-admission screening (PAS) was implemented in Virginia in 1977 to ensure that Medicaid-eligible individuals placed in nursing facilities actually require Nursing Facility Care. In 1982, § 32.1-327.2 of the *Code of Virginia* was revised to require PAS for all individuals who will be eligible for Community or Institutional Long-Term Care. Revised in 1985, § 32.1-330 of the *Code of Virginia* states:

§ **32.1-330**. **Pre-admission screening required.** - All individuals who will be eligible for Community or Institutional Long-Term Care Services, as defined in the Virginia State Plan for Medical Assistance, shall be evaluated to determine their need for Nursing Facility Services as defined in that plan. The Department shall require a pre-admission screening of all individuals who, at the time of application for admission to a certified Nursing Facility as defined in § 32.1-123, are eligible for medical assistance or will become eligible within 180 days following admission. For community-based screening, the Screening Committee shall consist of a Nurse, Social Worker, and Physician, who are employees of the Department of Health or the local Department of Social Services. For institutional screening, the Department shall contract with acute care hospitals.

PAS determines whether an individual needs Nursing Facility Services and, when appropriate, authorizes either Nursing Facility or Community-Based Long-Term Care. PAS is the first level of authorization for Medicaid reimbursement of Nursing Facility Care and Home- and Community-Based Care Waiver Services (e.g. Case Management, Personal Care, Respite Care, Skilled Nursing, and nutritional supplements).

Regarding Mental Illness (MI), Mental Retardation (MR), and/or Related Condition (RC) Screenings:

The Omnibus Budget Reconciliation Act (OBRA) of 1987, Part 2, Subtitle C of Title IV, added §1919 to the Social Security Act. Section 1919 (e)(7) requires states to have PAS programs to identify individuals with mental illness (MI), mental retardation (MR), or a related condition (RC) using criteria established by the Secretary of Health and Human Services. Specifically, § 1919(b)(3)(F) prohibits a Nursing Facility from admitting any new resident who has MI, MR, or RC unless that individual has been determined by the State Mental Health Authority (MHA) or Mental Retardation Authority (MRA) to require the level of services provided by a Nursing Facility. If so, the State MHA or MRA will determine whether active treatment is required. Therefore, Virginia's Nursing Facility PAS Program includes the participation of mental health professionals from the local Community Services Boards (CSBs) and a representative from the State MHA and MRA (the Department of Mental Health, Mental Retardation and Substance Abuse Services - DMHMRSAS) in those cases where MI/MR/RC are a factor.

There is an additional screening component in place for individuals with a diagnosis of MI/MR/RC. The DMAS-95 MI/MR Level I screening is the first step to identify MI/MR/RC for individuals seeking Nursing Facility placement. The Level II MI/MR/RC screening determines if the individual may benefit from additional Specialized Services but does not preclude them

from receiving services in a Nursing Facility or a Home- and Community-Based Care Waiver that has a Nursing Facility as the alternative institutional general scope of placement. In those cases in which the PAS team determines that the individual requires assessment for conditions of MI, MR, or RC, the PAS team will refer to the appropriate contractor hired by the State MHA/MRA for a Level II assessment for Nursing Facility placement.

The DMAS-101A form is the first step in identifying MI/MR/RC for individuals seeking placement in one of Virginia's Home- and Community-Based Care Waiver programs. The DMAS-101B screening determines if the individual may benefit from additional Specialized Services. For Home- and Community-Based Care Waiver Services, the individual is referred to the Community Services Board (CSB), which will become involved with the PAS team in determining the appropriate placement authorization.

Exception: Individuals with a condition of AIDS (Acquired Immune Deficiency Syndrome), or who are HIV+ (Human Immunodeficiency Virus) and symptomatic, are exempt from the requirement for a Level II assessment for conditions of MI/MR/RC, due to the terminal nature of their illness. Individuals with AIDS, or who are HIV+ and symptomatic, are also exempt from the 101A screening process for the waivers related to MI/MR/RC.

POPULATION TO BE SCREENED

Medicaid-Eligible Individuals

Individuals in the community or in acute-care hospitals must be screened to determine the necessity for Nursing Facility placement if the individual is currently financially Medicaid-eligible, anticipates that he/she will be financially eligible within 180 days of the receipt of Nursing Facility Care, or if the individual is at risk of Nursing Facility placement. Individuals at risk of Nursing Facility placement, have several Home- and Community-Based Care Waiver options available to them, in addition to placement in a Nursing Facility. The waiver options available for individuals that meet Nursing Facility level of care are: Technology Assisted, Elderly and Disabled with Consumer-Directed (EDCD) Services, and the AIDS/HIV Waivers.

This requirement assures that all individuals, who will be eligible for Medicaid payment for Community or Nursing Facility Long-Term-Care Services, have been evaluated to determine the need for Nursing Facility level of service.

POPULATION EXCLUSIONS TO THE PRE-ADMISSION SCREENING PROCESS

Private Pay Individuals

All individuals, who are applying to enter a Nursing Facility and are not anticipated to be Medicaid-eligible within 180 days subsequent to Nursing Facility admission, are considered to be private pay patients and must be assessed to determine the need for Nursing Facility Care and any active treatment for MI/MR/RC. The Nursing Facility is responsible for conducting this assessment, identifying those persons potentially having a diagnosis of MI/MR/RC, and referring them to their private practitioners for further diagnostic evaluation. Individuals applying for admission to a Nursing Facility from a military hospital shall be treated as private pay patients.

The PAS team is not responsible for conducting assessments for private pay patients in either the acute care or community setting and cannot receive Medicaid reimbursement for a screening of a private pay patient.

Mental Health/Mental Retardation Facilities

Individuals, who are residents in state mental health and mental retardation facilities or facilities for the mentally retarded that seek Nursing Facility placement directly from these facilities, must be screened. These screenings will be completed by the Virginia Department of Medical Assistance Services (DMAS) in cooperation with representatives of DMHMRSAS and, therefore, are not the responsibility of the local or acute-care screening teams.

Veterans' Administration Medical Center or Other Military Hospital Facility

Individuals in Veterans' Administration Medical Centers (VAMC), who are applying to enter a Nursing Facility, will be assessed by the VAMC discharge planning staff to determine the need for Nursing Facility care and to identify any conditions of MI/MR/RC that require further Level II assessment. The VAMC discharge planning staff will use their own Veterans' Administration Assessment Form, the Community Nursing Facility Care Form, and the MI/MR Supplement for the Level I assessment.

TRANSFERS

Nursing Facility - Awaiting Placement

At times, an individual who has been assessed by the local screening team as appropriate for Nursing Facility Care will have to remain in the community while waiting for a Nursing Facility bed. In these instances, it is appropriate for the individual to receive services through the EDCD or HIV/AIDS Waivers until Nursing Facility placement takes place.

Nursing Facility-to-Hospital Transfers

Screening teams in hospitals do not complete a PAS for individuals who are admitted to a hospital from a Nursing Facility when the individual is to be discharged back to either the same or a different Nursing Facility, and the individual continues to meet Nursing Facility level of care based upon current level of functioning. If an individual is admitted to a hospital from a Nursing Facility and the individual's condition has not changed, but placement in a different Nursing Facility is sought, a new PAS is not required. The second Nursing Facility would be required to complete necessary documentation for Medicaid admission certification. For individuals with a diagnosis, history, or presenting evidence of MI/MR/RC, there is no need for a second Level II screening unless the individual's mental health status has changed. The screening team, when completing a second PAS on an individual with a condition of MI/MR/RC, must note on the DMAS-95 MI/MR Form that there has been no change in that individual's mental status since the previous Level II assessment and, therefore, that assessment continues to be valid. The Level II assessment may be obtained from the Nursing Facility.

Nursing Facility-to-Waiver Transfers

When an individual is discharged from a Nursing Facility and is expected to receive services under one of the Medicaid waivers (EDCD or AIDS/HIV Waiver), a new PAS is not required. If the individual was not screened prior to admission to the Nursing Facility, the locality in which the individual resides must complete the PAS prior to the individual receiving services under the waiver.

Nursing Facility-to-Nursing Facility Transfers

Individuals residing in a licensed Nursing Facility and desiring a transfer to another Nursing Facility in the Commonwealth of Virginia are not required to be screened by local or hospital screening teams. The Nursing Facility from which the individual is transferring must send a copy of all screening materials to the receiving Nursing Facility. The receiving Nursing Facility is then responsible for initiating the appropriate documentation for admission certification purposes.

Waiver-to-Nursing Facility Transfers

An individual entering a Nursing Facility, who anticipates Medicaid payment for his/her stay by DMAS, must first be screened to determine if he/she meets established Medicaid Nursing Facility level-of-care criteria. When an individual is expected to enter a Nursing Facility directly from the EDCD or AIDS/HIV Waiver, a new PAS is not required.

SPECIAL CIRCUMSTANCES AND TRANSFERS

Rehabilitation Hospital or Rehabilitation Units-of-Acute-Care Hospital Transfers

The acute-care screening team is responsible for the PAS assessment and authorizations for Nursing Facility level of care or Home- and Community-Based Care Services for individuals in units-of-acute-care hospitals.

Out-of-State Transfers and Admissions

For individuals who reside out-of-state and wish direct admission to a Nursing Facility in Virginia, a PAS is not required. The admitting Nursing Facility is responsible for ensuring that the individual meets the established criteria for Nursing Facility placement and that the federal requirements related to MI/MR/RC are met upon admission. If not a direct admission, then the individual is subject to PAS by the locality in which the individual is residing.

For individuals who reside out-of-state and seek admission to Home- and Community-Based Care Services, the screening team in the locality in which the individual will reside must complete a PAS. The locality may screen the individual once the individual relocates.

AUTHORIZATIONS AND REFERRALS

Nursing Facility Authorization

The screening team may establish that Nursing Facility level of care is appropriate for an individual after the PAS has been completed. In the case where a documented condition of MI/MR/RC is present and requires completion of the Level II assessment and after the State MHA/MRA has returned the Level II evaluation assessment, the screening team can authorize Nursing Facility level of care.

The individual must be given the choice between Nursing Facility level of care and placement in one of the Home- and Community-Based Care Waiver programs, such as the EDCD or AIDS/HIV Waiver. During the authorization process, the screening team will assist the individual with determining what level of care and services, if any, are needed; who will provide the services; and the setting where services will be provided. If the MHA/MRA has recommended active treatment, the CSB will determine the setting for care in order to meet the active treatment needs. If a Level II assessment indicates Nursing Facility level of care cannot be authorized, the screening team and MHA/MRA must confer with the individual about placement options.

The screening team must inform the individual or family of all of the following requirements:

- That the authorization for Medicaid-funded services does not mean that the individual will definitely become financially Medicaid-eligible;
- That financial eligibility for Medicaid coverage must be determined by an eligibility worker at the local Department of Social Services (DSS) office;
- That Medicaid cannot reimburse for services unless the individual has been determined to be financially Medicaid-eligible and meets the level-of-care criteria for service authorization; and
- That the individual may have a financial responsibility in the form of a co-payment for Medicaid-funded services, as determined by the eligibility worker at the local DSS office.

Referrals for Nursing Facility Placement

A referral to a Nursing Facility can be initiated when the screening team completes an assessment, determines that an individual meets the criteria for Nursing Facility care and that no Level II assessment is indicated, or has received authorization for Nursing Facility care from the MH/MRA on the Level II assessment, and DMAS Community-Based Care Services are not appropriate. The screening team will complete a DMAS-96 form and send a letter indicating the decision to the individual who was screened.

When Nursing Facility placement is approved, all of the following procedures apply:

- The screening team will send the Nursing Facility providing the care: (a) the original UAI (Virginia Uniform Assessment Instrument) and DMAS-95 Level I (if appropriate Level II) MI/MR; (b) a copy of the DMAS-96 form; and (c) a copy of the DMAS-20 form.
- The screening team will send a letter to the individual screened with a copy to the referral source indicating the decision of the team. The individual will receive appeal rights within this decision letter containing instructions on how to appeal the screening team's decision.
- The screening team will send a copy of the completed DMAS-96 form to the appropriate local DSS office, Eligibility Section.
- Within 30 days of the assessment date, the screening team will send to First Health Services Corporation (FHSC) the completed PAS screening package. This package includes: (a) the original UAI and DMAS-95 Level I (if appropriate Level II) MI/MR; (b) a copy of the DMAS-96 form; (c) a copy of the DMAS-20 form; and (d) a copy of the decision letter sent to the individual. The screening team must send the completed screening information to:

  Pre-Admission Screening
  First Health Services Corporation
  P.O. Box 85083
  Richmond, Virginia 23285-5083

The screening team must retain the original UAI, DMAS-96 form, and a copy of the decision letter for a period of not less than five (5) years from the date of the screening.

DMAS Authority for Authorization of Medicaid Payment

Screening teams have the initial responsibility and authority for authorizing Medicaid reimbursement for Nursing Facility and Community-Based Care Services. Providers of care are still responsible for requesting authorization for services. In those instances when the assessment documentation does not clearly indicate that the individual meets Nursing Facility care criteria, Medicaid-covered services cannot be authorized. Any information, which is needed to support the screening team's level-of-care decision, must be documented on page 12 of the UAI.

DMAS does, however, have the ultimate responsibility for assuring appropriate placement in Nursing Facility and Community-Based Care Services and, thus, can overturn any decision made by the screening team. Any authorization made by the screening team is subject to change based on any change that occurs in the individual's condition or circumstances between the time the authorization occurs and the service provider initiates contact with the individual. If, for any reason, the Nursing Facility or community-based care provider finds that the individual is inappropriate for admission to the service, that Nursing Facility or provider must notify the individual in writing of the finding and send a copy to both DMAS and the local screening team.

DMAS will review the Nursing Facility or provider's findings and communicate with the individual and the provider as needed. In those cases where the individual has been referred for a Level II assessment, the responsibility and authority for the authorization of services is shared

with the state MH/MRA and DMAS. The Level II authorization must occur prior to service initiation for Nursing Facility Services.

Pre-Admission Screening of Transfers to Nursing Facilities from State Mental Health and Mental Retardation Facilities

Individuals, who are residents in state mental health and mental retardation facilities and are seeking Nursing Facility placement directly from the state institution, must be screened. DMAS has established a Nursing Facility Pre-Admission Screening (PAS) Committee in the central DMAS office, which has the responsibility and authority for screening all individuals in state facilities for MH/MR who are seeking Nursing Facility admission and are Medicaid-eligible at the time of the Nursing Facility admission. This PAS Committee includes representatives from DMAS and DMHMRSAS.

These screenings are not the responsibility of the local or acute care PAS Committees. Medicaid payment will not be made to the Nursing Facility without the DMAS Nursing Facility PAS Committee's authorization and approval prior to the individual's admission to the Nursing Facility. Nursing Facility PAS is **not** required when an individual is transferring from a community home for the mentally retarded to a state home for the mentally retarded.

All individuals in these facilities, who are being discharged to a Nursing Facility and are Medicaid-eligible or will become Medicaid-eligible within 180 days subsequent to Nursing Facility placement, should be referred to DMAS so that the Nursing Facility PAS can be performed. This referral must be made by the facility where the individual is residing at the time a discharge to a Nursing Facility is anticipated. The referral must be sent to:

Pre-Admission Screening Committee
Facility and Home-Based Services Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The referral must include the following:

- A completed UAI;
- A completed Level II assessment;
- A completed history and physical; and
- This Nursing Facility information must be sent to the Nursing Facility PAS Committee at least two weeks in advance of the anticipated discharge from the facility for the mentally ill or mentally retarded. The individual must not be placed in a Nursing Facility without the DMAS PAS Committee's approval. The facility for the mentally ill or mentally retarded will receive this approval in writing, and a copy of the written approval must be supplied to the Nursing Facility at the time of the transfer.

PRE-ADMISSION RESPONSIBILITIES OF THE NURSING FACILITY

It is the Nursing Facility's responsibility not to accept residents without pre-authorization who are, or will be, Medicaid-eligible in less than 180 days after Nursing Facility admission. Moreover, the Nursing Facility must not admit any new resident who is determined to be mentally ill or mentally retarded unless DMHMRSAS has determined whether the individual requires the level of services provided by a Nursing Facility and, if so, has determined whether Specialized Services are needed. Therefore, all new Admission Officers, or anyone assuming the responsibility in the absence of an Admission Officer, should be made aware of this requirement for new admissions. **DMAS will not pay for any period of stay pre-dating the authorization date approved by the Nursing Facility PAS Committee.**

It is the responsibility of the Nursing Facility to ensure that forms completed by the PAS Committees reflect a need for Nursing Facility Care and that all requirements for screening of MI/MR/RC are met. For example, if the MI/MR Screening Form states "no known diagnosis," the facility must review the package to ensure that a MI/MR diagnosis is not listed elsewhere.

For individuals who are not Medicaid-eligible at the time of admission, the Admission Coordinator, who has initial contact with the resident representative, should provide that representative with the approximate monthly cost figures for room and board plus any estimated ancillary charges related to the Nursing Facility stay for at least six months. The resident's representative should also be asked if the resident has or will have funds to sufficiently cover the estimated costs plus any other expenses known to the resident or representative, or if the resident has already applied for or expects to apply for Medicaid. Nursing facilities must also notify all new admissions and their families that Resource Assessments are available upon request. Chapter VII contains the details about Resource Assessments.

In the interview, inquiries should be made concerning the source and approximate amounts of regular income from all sources, including but not limited to: Social Security, employee retirement, interest-bearing accounts, etc.; the cash value of insurance policies or bonds; the value of real property minus liens or mortgages; burial funds and whether they are irrevocable; and any outstanding medical bills or other debts which would serve to rapidly deplete financial resources.

PRE-ADMISSION SCREENING AND NURSING FACILITY PLACEMENT OF INDIVIDUALS WITH MENTAL ILLNESS AND/OR MENTAL RETARDATION

The Omnibus Budget Reconciliation Act (OBRA) of 1987 prohibits a Nursing Facility from admitting any individual, regardless of pay status, who has a condition of MI/MR/RC unless that individual has been determined to require the level of services provided by a Nursing Facility, and a determination has been made regarding the individual's need for Specialized Services. In addition, federal law also requires that all Nursing Facility residents with conditions of MI/MR/RC be assessed whenever there is a significant change to determine whether or not specialized services are still required. DMHMRSAS, which is the State Mental Health Authority and Mental Retardation Authority (State MHA/MRA) for PAS and Resident Review purposes, coordinates this Resident Review process and is responsible for making determinations regarding the need for Specialized Services.

The definition of a Nursing Facility includes nursing facilities that are operated by DMHMRSAS. These facilities are Hiram Davis Medical Center (skilled Nursing Facility), Adult Treatment Center and Skilled Nursing Facility Unit of Central Virginia Training Center, Skilled Nursing Facility Unit of Southside Virginia Training Center, Eastern State Hospital (skilled Nursing Facility), and Southwestern Virginia Mental Health Institute (Nursing Facility).

Level I Identification Process

For Medicaid recipients, the purposes of the Level I screening are to determine if the applicant has a condition of MI, MR/RC, or both, **and** to determine if he/she meets Nursing Facility level-of-care criteria. If the Level I screening process determines that the individual has a condition of MI, MR/RC, or both, a Level II screening **must** be completed before the individual can be admitted. The Level I process, which includes the UAI, the DMAS-95 MI/MR Supplement, and the DMAS-96 form, is completed by Pre-Admission Screening Committees (PASCs) for Medicaid-eligible individuals and those who expect to become Medicaid-eligible within 180 days.

For non-Medicaid eligible individuals, the receiving Nursing Facility must ensure that the appropriate screenings for MI/MR/RC are conducted at the time of admission. **Every Medicaid-certified Nursing Facility must have a policy on file describing how the MI/MR screenings will be handled for non-Medicaid-eligible individuals.**

By federal law, an individual shall not be admitted to a Nursing Facility unless the Level I screening has been completed, and, if it is determined that the individual has a condition of MI/MR/RC, then he/she shall not be admitted until the Level II assessment has been completed. In addition, when a PAS has not been performed prior to admission or a Resident Review is not performed in a timely manner, but either process is performed at a later date, federal financial participation (FFP) is available only for services furnished after the screening or review has been performed. Medicaid will **not** generate a Permission-to-Bill letter and will not make payments for a Nursing Facility stay until all necessary assessments are completed.

The completed Level I screening form must be placed in the resident's medical record. All determinations made by the State MHA/MRA must be recorded in the individual's medical record. DMAS staff may review the resident's medical records on-site to determine if the facility is in compliance with the PAS requirements described herein.

The Level I identification function must provide at least, in the case of first-time identifications, for the issuance of written notice to the individual or resident and his/her legal representative if the individual is suspected of having MI or MR/RC and is being referred to the entity contracted to complete the Level II evaluation. The PASC is responsible for sending this notice to Medicaid-eligible individuals who are referred for a Level II evaluation. The admitting Nursing Facility is responsible for sending the notice to non-Medicaid-eligible individuals. At the end of this chapter, a sample notice is included which may be used for this purpose. The DMAS-95 MI/MR Level I Supplement is also shown at the end of the chapter.

Summary of a Nursing Facility's Responsibility for the Level I Process

- No individual may be admitted to the facility without a completed UAI and MI/MR Level I Supplement. If the applicant is Medicaid-eligible or will be Medicaid-eligible within 180 days of admission, the PASCs will perform the Level I screening. If the applicant is not Medicaid-eligible, the admitting Nursing Facility is responsible for ensuring that the MI/MR screening is completed prior to the individual's admission. All Medicaid-certified nursing facilities must have on file a policy approved by DMAS that describes how they will handle the required MI/MR screenings. A sample policy is included in the "Exhibits" section at the end of this chapter.

- If any applicant is determined, as a result of the Level I screening, to need a referral for the Level II screening (i.e., he/she has a condition of MI/MR/RC as defined below), then he/she may not be admitted until a Level II evaluation has been completed and DMHMRSAS has determined that the individual's needs can be met in a Nursing Facility. A Nursing Facility will be at risk of losing FFP if individuals are admitted without the required screenings.

- If any applicant is currently receiving services through the EDCD Waiver, the Nursing Facility is responsible for completing a Level I screening once the applicant is admitted into the Nursing Facility. If it is determined that the recipient requires a Level II evaluation, then the Nursing Facility must initiate the Resident Review process by contacting:

  OBRA Consultant
  DMHMRSAS
  P.O. Box 1797, 10th Floor - Jefferson
  Richmond, VA 23218
  1-804-371-0360

Level II Assessments

A Level II assessment is required for any individual for whom the Level I screening has resulted in the determination that: 1) the individual meets the level-of-care criteria required to demonstrate the need for Nursing Facility Care; and 2) the individual has a diagnosis, history of, or presents evidence of a condition of MI/MR/RC. However, if the individual meets the above criteria but also meets one of the following categorical determinations, a Level II assessment does not have to be completed. These determinations may only be applied following the Level I review and only if existing data on the individual appears to be current and accurate and are sufficient to allow the evaluator to readily determine that the individual fits into the category established. Sources of existing data that could form the basis for applying a categorical determination include hospital records, physician's evaluations, election of hospice status, and records of community mental health, mental retardation, or developmental disability providers. The categorical determinations not requiring a Level II assessment are:

- A diagnosis of dementia (such as Alzheimer's disease) in the absence of a primary diagnosis of MI;

- A terminal illness in which a physician has documented that life expectancy is less than six months; or

- A severe physical illness such as a coma, functioning at a brain-stem level, or other conditions which result in a level of impairment so severe (end stage) that the individual could not be expected to benefit from specialized services. When this category is used, written documentation, signed by a physician, must be available which fully describes the severity of the condition. A diagnosis alone does not constitute a severe physical illness.

The categories listed above are the only situations in which an individual with a condition of MI/MR/RC can be admitted to a Nursing Facility without having received a Level II assessment. Note that Convalescent Care has been eliminated as an exclusionary category. Other changes include revised definitions for what constitutes MI/MR/RC for PASARR (Pre-Admission Screening and Annual Resident Reviews) purposes and a change in the application of the severe physical illness category.

When required, a Level II determination must be made within an annual average of seven-to-nine working days of the referral for evaluation, including time in which the CSB prepares the recommendation (five-to-seven days for the CSB recommendation and two-to-four days for the DMHMRSAS decision). DMHMRSAS may convey determinations orally to nursing facilities and the individual and confirm them in writing.

The following entities must be notified of a Level II determination: the evaluated individual and his/her legal representative; the admitting or retaining Nursing Facility; the attending physician; and the discharging hospital. Each notice must include: 1) whether a Nursing Facility level of services is needed; 2) whether specialized services are needed; 3) the placement options available to the individual; and 4) the rights of the individual to appeal the determination.

<u>Summary of a Nursing Facility's Responsibility for the Level II Process</u>

- If an applicant is determined, as a result of the Level I screening, to have a condition of MI/MR/RC, or both, as described below, he/she may not be admitted to the Nursing Facility until a Level II evaluation has been performed and DMHMRSAS determines that Nursing Facility placement is appropriate.

- For applicants who are Medicaid-eligible or who expect to become Medicaid-eligible within 180 days and who require a Level II evaluation, the PASC will refer the screening package to the Level II contractor. The contractor will gather the required Nursing Facility information and make a recommendation to DMHMRSAS. DMHMRSAS will determine whether Nursing Facility placement is appropriate and what services may be required for the individual's MI/MR/RC.

- For non-Medicaid applicants who require a Level II evaluation, the Nursing Facility must gather the appropriate assessments and submit them directly to DMHMRSAS for review.

DEFINITIONS

Mental Illness: An individual is considered to have a **serious mental illness** if the individual meets the following requirements for diagnosis, level of impairment, and duration of illness.

Diagnosis: The individual has a major mental disorder diagnosable under the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, revised in 2004. The mental disorders include schizophrenia, mood disorders, delusional (paranoid) disorders, psychotic disorders not listed elsewhere, panic or other severe anxiety disorders, somatoform disorder, personality disorder, or other mental disorders that **may lead to a chronic disability**. The disorder is not a primary diagnosis of dementia, including Alzheimer's disease, a related disorder, or a secondary diagnosis of dementia, unless the primary diagnosis is a major mental disorder as defined here.

The following list includes those disorders, which are considered to be serious mental disorders for the purposes of PASARR: schizophrenia (including disorganized, catatonic, undifferentiated, and paranoid types); mood including bipolar disorder [mixed, manic, cyclothymia, depressed, seasonal, not otherwise specified (NOS)]; major depression (single episode or recurrent, chronic, melancholic or seasonal), depressive disorder (NOS); cyclothymia; dysthymia (primary, secondary, early or late onset); paranoid (including delusional, erotomanic, grandiose, jealous, persecutory, somatic, unspecified, or induced psychotic disorder); panic or other severe anxiety disorder (including panic disorder with agoraphobia, agoraphobia with or without history of panic disorder, social phobia, generalized anxiety disorder, obsessive compulsive disorder, post-traumatic stress disorder); somatoform disorder [includes somatization disorder, conversion disorder, somatoform pain disorder, hypochondriasis, body dysmorphic disorder, undifferentiated somatoform disorder, somatoform disorder (NOS)]; personality disorder (includes paranoid, schizoid, schizotypal, histrionic, narcissistic, antisocial, borderline, avoidant, dependent, obsessive compulsive, passive aggressive, and NOS); other psychotic disorder (includes schizophreniform disorder, schizoaffective disorder [bipolar/depressive], brief reactive psychosis, atypical, and NOS); or other mental disorder that may lead to a chronic disability.

Level of Impairment: The disorder results in functional limitations in major life activities within the past three to six months that would be appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis:

- Interpersonal Functioning - The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation;

- Concentration, Persistence, and Pace - The individual has serious difficulty in sustaining focused attention long enough to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, manifests inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; or

- Adaptation to Change - The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction; manifests agitation as well as exacerbated signs and symptoms associated with the illness or withdrawal from the situation; or requires intervention by the mental health or judicial system.

Recent Treatment: The treatment history indicates that the individual has experienced at least one of the following:

- Psychiatric treatment more intensive than outpatient care more than once in the past two years (e.g., partial hospitalization or inpatient hospitalization); or

- Within the last two years, due to the mental disorder, the individual experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Mental Retardation or Related Condition: An individual is considered to have **mental retardation** if he/she has a level of retardation (mild, moderate, severe, or profound) described in the American Association on Mental Retardation's (AAMR) *Manual on Classification in Mental Retardation* (1989); or is considered to have a related condition. A person with related conditions means individuals who have a severe chronic disability that meets all of the following conditions:

- It is attributable to cerebral palsy or epilepsy or any other condition, other than mental illness, found to be closely related to mental retardation because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons;

- It is manifested before the person reaches age 22;

- It is likely to continue indefinitely; and

- It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

Dementia: An individual is considered to have dementia if he/she has a primary diagnosis of dementia, as described in the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition, revised in 2004) or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder. In other words, if an individual has a primary diagnosis of dementia, including Alzheimer's disease, he/she does not have to be referred for a Level II evaluation. However, if an individual has a diagnosis of dementia, but the primary diagnosis is a major mental disorder as defined above, then the individual must be referred for a Level II evaluation. If an individual has a diagnosis of dementia in addition to MR/RC, the individual must be referred for a Level II evaluation.

ADMISSIONS, RE-ADMISSIONS, AND INTERHOME TRANSFERS

An individual is a **new admission** when he/she is admitted to any Nursing Facility for the first time or does not qualify as a re-admission. New admissions are subject to PAS.

An individual is a **re-admission** if he/she was re-admitted to a Nursing Facility from a hospital to which he/she was transferred for the purpose of receiving care. Re-admissions are subject to annual resident review rather than PAS.

An **interhome transfer** occurs when an individual is transferred from one Nursing Facility to another Nursing Facility, with or without an intervening hospital stay. Interhome transfers are subject to annual resident review rather than PAS.

In cases of the transfer of a resident with MI/MR/RC from a Nursing Facility to a hospital or to another Nursing Facility, the transferring Nursing Facility is responsible for ensuring that copies of the resident's most recent PASARR and resident assessment reports accompany the transferring resident.

DETERMINATIONS AND PLACEMENT OF INDIVIDUALS WITH MI/MR/RC

If DMHMRSAS determines that a resident or applicant for admission to a Nursing Facility requires a Nursing Facility level of service, the Nursing Facility may admit or retain the individual. If DMHMRSAS determines that a resident or applicant for admission requires both a Nursing Facility level of service and Specialized Services for MI/MR/RC, the Nursing Facility may admit or retain the individual, and DMHMRSAS must provide or arrange for the provision of the Specialized Services needed by the individual while he/she resides in the Nursing Facility.

If DMHMRSAS determines that an applicant for admission to a Nursing Facility does not require Nursing Facility Service, the applicant cannot be admitted. Nursing Facility Services are not a covered Medicaid service for that individual, and further screening is not required.

If DMHMRSAS determines that a resident requires neither the level of services from a Nursing Facility nor Specialized Services for MI/MR/RC, regardless of the length of stay in the facility, the state must: 1) arrange for the safe and orderly discharge of the resident from the facility; and 2) prepare and orient the resident for discharge.

For any resident who has continuously resided in a Nursing Facility for at least 30 months prior to the date of the determination, and who requires only specialized services, the state must, in consultation with the resident's family or legal representative and caregivers: 1) offer the resident the choice of remaining in the Nursing Facility or of receiving services in an alternative appropriate setting; 2) inform the resident of the institutional and non-institutional alternatives available; 3) clarify the effect on eligibility for Medicaid services if the resident chooses to leave the Nursing Facility, including its effect on re-admission to the Nursing Facility or eligibility for Community-Based Services; and 4) regardless of the resident's choice to remain in the Nursing Facility or to be discharged to a community setting, provide or arrange for the provision of Specialized Services for the MI/MR/RC.

For any resident who has not continuously resided in a Nursing Facility for at least 30 months before the date of the determination, the state must, in consultation with the resident's family or legal representative and caregivers: 1) arrange for the safe and orderly discharge of the resident from the Nursing Facility; 2) prepare and orient the resident for discharge; and 3) provide or arrange for the provision of specialized services for the MI or MR/RC.

For the purposes of establishing length of stay in a Nursing Facility, the 30 months of continuous residence in a Nursing Facility or longer is calculated back from the date of the first annual resident review determination, which finds that the individual is not in need of Nursing Facility level of services. The 30 months of continuous residence in a Nursing Facility may include temporary absences for hospitalization and therapeutic leave and may consist of consecutive residences in more than one Nursing Facility.

Placement of an individual with MI/MR/RC in a Nursing Facility may be considered appropriate **only** when the individual's needs are such that he/she meets the minimum standards for admission and the individual's needs for treatment do not exceed the level of services, which can be delivered in the Nursing Facility to which the individual is admitted either through Nursing Facility Services alone or, when necessary, through Nursing Facility Services supplemented by specialized services provided by or arranged for by the state.

PASARR EVALUATION CRITERIA

The state's PASARR program must identify all individuals who are suspected of having MI or MR/RC as defined herein. The identification function and determination, that Nursing Facility criteria are met, is termed Level II. Level II is the function of evaluating and determining whether Nursing Facility placement is appropriate to meet the individual's MH/MR needs and whether specialized services are needed.

Evaluations performed under PASARR and PASARR notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated. PASARR evaluations must involve the individual being evaluated, the individual's legal representative, if one has been designated under state law, and the individual's family if available and the individual or the legal representative agrees to family participation. When parts of a PASARR evaluation are performed by more than one evaluator, there must be interdisciplinary coordination among the evaluators.

All Nursing Facility information, that is necessary for determining whether it is appropriate for the individual with MI or MR/RC to be placed in a Nursing Facility or in another setting, should be gathered from all applicable portions of the PASARR evaluation. Determinations of the need for Nursing Facility level of care and specialized services are interrelated and must be based upon a comprehensive analysis of all data concerning the individual.

Evaluators may use relevant evaluative data obtained prior to initiation of PAS or annual Resident Review if the data is considered valid, accurate, and reflects the current functional status of the individual. However, in the case of individualized evaluations, the PASARR program may need to gather additional Nursing Facility information to supplement and verify the currency and accuracy of existing data and to assess proper placement and treatment.

For individualized PASARR determinations, findings must be issued in the form of a written evaluative report which: 1) identifies the name and professional title of the person(s) who performed the evaluation(s) and the date that each portion of the evaluation was completed; 2) provides a summary of the medical and social history, including the positive traits or developmental strengths and weaknesses or developmental needs of the evaluated individual; 3) when Nursing Facility Services are recommended, identifies the specific services that are required to meet the evaluated individual's needs; 4) if Specialized Services are not recommended, identifies any specific MR/RC or MH Services of a lesser intensity than Specialized Services that are required to meet the evaluated individual's needs; 5) if Specialized Services are recommended, identifies the specific MR/RC or MH Services required to meet the evaluated individual's needs; and 6) includes the basis for the report's conclusions.

For categorical PASARR determinations, findings must be issued in the form of an abbreviated written evaluative report which: 1) identifies the name and professional title of the person applying the categorical determination and the date on which the application was made; 2) explains the categorical determination(s) that has (have) been made and, if only one of the two required determinations can be made categorically, describes the nature of any further screening which is required; 3) identifies, to the extent possible based on the available data, Nursing Facility Services, including any Mental Health or Specialized Psychiatric Rehabilitative Services, that may be needed; and 4) includes the basis for the report's conclusions.

For both categorical and individualized determinations, evaluation findings must correspond to the person's current functional status, mental health, and mental retardation status as documented in medical and social history records. Evaluation findings must be interpreted and explained to the individual and, where applicable, to a legal representative designated under state law by the assessment team or DMHMRSAS. The evaluation report must be sent to the individual and his/her legal representative and DMHMRSAS in sufficient time to meet the required time frames, the admitting or retaining Nursing Facility, the individual's attending physician, and the discharging hospital if the individual is seeking Nursing Facility admission from a hospital. The evaluation may be terminated at any time it is discovered that the individual being evaluated does not have MI or MR/RC or has a primary diagnosis of dementia or a non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness, and does not have a diagnosis of MR or a related condition.

SPECIALIZED SERVICES

For **mental illness**, Specialized Services are defined as the services specified by the state which, combined with services provided by the Nursing Facility, result in the continuous and aggressive implementation of an individualized Plan of Care (POC) that is: 1) developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals (QMHPs), and, as appropriate, other professionals; 2) prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and 3) is directed towards diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his/her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of Psychiatric Services to below the level of Specialized Services at the earliest possible time.

For Nursing Facility residents who are determined to be a danger to themselves or others due to MI/MR/RC, the Nursing Facility must coordinate admission to an inpatient psychiatric hospital.

For **mental retardation**, Specialized Services are defined as the services specified by the state which, combined with services provided by the Nursing Facility or other service providers, result in treatment that meets the requirements of 42 CFR §483.440(a)(1), which states that a continuous Specialized Services program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, and health and related services, is directed toward the following:

- The acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; and
- The prevention or deceleration of regression or loss of current optimal, functional status.

The state must provide or arrange for the provision of Specialized Services to all Nursing Facility residents with MI/MR/RC whose needs are such that continuous supervision, treatment, and training by qualified MH/MR personnel is necessary as identified by their Level I and II assessments. The Nursing Facility must provide MH or MR/RC Services, which are of a lesser intensity than Specialized Services to all residents who need such services.

Services the Nursing Facility is responsible for providing residents include, but are not limited to:

- Physical Therapy;
- Speech Language Pathology Services;
- Occupational Therapy;
- Restorative Nursing;
- Behavior Management interventions that do not require ongoing consultation and monitoring by a licensed Psychiatrist or Psychologist;
- Basic grooming and hygiene needs;
- Nutritional needs, including supplements and assistance with eating;
- Adjustment needs resulting from admission to a Nursing Facility and ongoing psychosocial emotional support; and
- Non-customized durable medical equipment (DME) and supplies.

Specialized Services that are to be provided by the state are as follows. DMHMRSAS will ensure the provision of services when they are provided by a non-Medicaid-enrolled provider or when the services are not covered by Medicaid. The services are:

- Partial Hospitalization;
- Transportation to Medicaid-covered services or Specialized Services necessary to treat conditions of MI or MR;
- Psychosocial Rehabilitation;
- Crisis Intervention;
- Customized DME for residents without a patient pay that would allow the resident to participate in Specialized Services;
- Behavior Management interventions requiring ongoing consultation and monitoring by a licensed Psychiatrist or Psychologist;
- One-to-one supervision necessary for Behavior Management;
- Vision or hearing needs related to conditions of MI/MR for persons over age 21;
- Dental needs resulting from conditions of MI/MR for persons over age 21;
- Supported employment for persons with MI/MR/RC;
- Case Management Services;
- Individual Psychotherapy;
- Day Treatment;
- Individual and Group Counseling; and
- Inpatient Psychiatric Care.

OUT-OF-STATE ADMISSIONS

The state in which the individual is a resident (or will be at the time he/she becomes eligible for Medicaid) must pay for the PASARR and make the required determinations. In the case of non-Medicaid-eligible applicants, the receiving Nursing Facility is responsible for ensuring that the appropriate screenings have been completed prior to the individual's admission.

RESIDENT REVIEWS

For each resident of a Nursing Facility who has a condition of MI/MR/RC, DMHMRSAS, as appropriate, must determine whether the individual requires the level of services provided by a Nursing Facility, an inpatient psychiatric hospital for individuals under age 21, an institution for mental disease (IMD) providing medical assistance to individuals age 65 or older, an intermediate care facility for the mentally retarded (ICF/MR), or Specialized Services for either MI/MR/RC. A review and determination must be conducted for each resident of a Nursing Facility who has MI/MR/RC, and DMHMRSAS must keep the Nursing Facility informed whenever there is a significant change in the Nursing Facility resident's mental or physical condition that results in noticeable improvement or deterioration in at least two (2) areas of physical or mental functioning, which has a bearing on his/her specialized needs. If an individual exhibits behaviors that meet the definition for mental illness during the course of his/her stay in a Nursing Facility, the Nursing Facility should indicate that on the Minimum Data Set (MDS) and inform the state MHA/MRA.

Nursing facilities must: (1) complete the MDS 2.0 for any "significant change" and (2) notify DMHMRSAS within seven calendar days of completing the Significant Change MDS 2.0 by submitting, via fax to 1-804-786-1836, the previous MDS 2.0 (long form) and the new MDS 2.0 (long form) to the OBRA office to initiate the resident review assessment. The OBRA Consultants make the referral for resident review assessments and also make the final determination regarding the resident's need for Specialized Services based on the resident review assessment conducted by the DMHMRSAS Contractor. Upon receipt of the referral, the assessment must be completed, and a determination must be made in writing within an annual average of seven-to-nine working days. The Contractor will submit the notification letter documenting the results of the Resident Review to the Nursing Facility Administrator, the resident, the attending Physician, and the legal guardian as appropriate.

The Significant Change screening requirements do not relieve the Nursing Facility of responsibility for completing a full assessment (as required by the CMS RAI Version 2.0 *User's Manual*), preparing an updated interdisciplinary team care plan, and providing the appropriate services that a recipient needs when a significant change occurs. Even if DMHMRSAS determines that the significant change screening does not necessitate the Level II Resident Review, the Nursing Facility must proceed as instructed above.

PLACEMENT OPTIONS

The placement options and required state actions resulting from PASARR are as follows:

- Can Be Admitted to a Nursing Facility - Any applicant for admission to a Nursing Facility who has MI/MR/RC and requires the level of services provided by a Nursing Facility, regardless of whether Specialized Services are also needed, may be admitted to a Nursing Facility, if the placement is appropriate. If Specialized Services are also needed, the state is responsible for providing or arranging for the provision of the Specialized Services.

- Cannot Be Admitted to a Nursing Facility - Any applicant for admission to a Nursing Facility who has MI/MR/RC and does not require the level of services provided by a Nursing Facility, regardless of whether Specialized Services are also needed, is inappropriate for Nursing Facility placement, and must not be admitted.

- May Choose to Remain in the Nursing Facility Even Though the Placement Would Otherwise Be Inappropriate - Any Nursing Facility resident with MI/MR/RC, who does not require the level of services provided by the Nursing Facility but does require Specialized Services and has continuously resided in a Nursing Facility for at least 30 consecutive months before the date of determination, may choose to continue to reside in the Nursing Facility or to receive covered services in an alternative appropriate institutional or non-institutional setting. Wherever the resident chooses to reside, the state must meet his/her Specialized Service needs. The determination notice must provide the Nursing Facility information concerning how, when, and by whom the various placement options available to the resident will be fully explained to the resident.

- Can Be Considered Appropriate for Continued Placement in a Nursing Facility - Any Nursing Facility resident with MI/MR/RC who requires the level of services provided by a Nursing Facility, regardless of the length of his/her stay or the need for Specialized Services, can continue to reside in the Nursing Facility, if the placement is appropriate.

- Cannot Be Considered Appropriate for Continued Placement in a Nursing Facility and Must Be Discharged (Short-Term Residents) - Any Nursing Facility resident with MI/MR/RC, who does not require the level of services provided by a Nursing Facility but does require Specialized Services and has resided in a Nursing Facility for less than 30 consecutive months, must be discharged to an appropriate setting where the state must provide Specialized Services. The determination notice must provide the Nursing Facility information on how, when, and by whom the resident will be advised of discharge arrangements and of his/her appeal rights under both PASARR and discharge provisions.

- Cannot Be Considered Appropriate for Continued Placement in a Nursing Facility and Must Be Discharged (Short- or Long-Term Residents) - Any Nursing Facility resident with MI/MR/RC, who does not require the level of services provided by a Nursing Facility and does not require Specialized Services, regardless of his/her length of stay, must be discharged. The determination notice must provide the Nursing Facility information on how, when, and by whom the resident will be advised of discharge arrangements and of his/her appeal rights under both PASARR and discharge provisions.

- Specialized Services Needed in a Nursing Facility - If a determination is made to admit or allow to remain in a Nursing Facility any individual who requires Specialized Services, the determination must be supported by assurances that the Specialized Services that are needed can and will be provided or arranged for in a timely manner by the state in which the individual resides.

The state PASARR system must maintain records of evaluations and determinations, regardless of whether they are performed categorically or individually, in order to support its determinations and actions and to protect the appeal rights of individuals subjected to PASARR.

The state PASARR system must establish and maintain a tracking system for all individuals with conditions of MI/MR/RC in nursing facilities to ensure that appeals and future reviews are performed.

EVALUATING THE NEED FOR NURSING FACILITY SERVICES AND NURSING FACILITY LEVEL OF CARE (PASARR/NURSING FACILITY)

For each applicant seeking admission to a Nursing Facility and each Nursing Facility resident who has MI/MR/RC, the evaluator must assess whether: (1) the applicant's or resident's total needs are such that his/her needs can be met in an appropriate community setting; (2) the individual's total needs are such that they can be met only on an inpatient basis, which may include the option of placement in a Home- and Community-Based Services Waiver program, but for which Inpatient Care would be required; (3) if Inpatient Care is appropriate and desired, the Nursing Facility is an appropriate institutional setting for meeting those needs; or (4) if Inpatient Care is appropriate and desired but the Nursing Facility is not the appropriate setting for meeting the individual's needs, another setting, such as an ICF/MR (including small, community-based facilities), an IMD providing services to individuals ages 65 or older, or a psychiatric hospital, is an appropriate institutional setting for meeting those needs.

In determining appropriate placement, the evaluator must prioritize the physical and mental needs of the individual being evaluated, taking into account the severity of each condition. At a minimum, the data relied on to make a determination must include: (1) evaluation of physical status (for example, diagnoses, date of onset, medical history, and prognosis); (2) evaluation of mental status (for example, diagnoses, date of onset, medical history, likelihood that the individual may be a danger to himself/herself or others); and (3) functional assessment (activities of daily living - ADLs).

EVALUATING WHETHER AN INDIVIDUAL WITH MENTAL ILLNESS REQUIRES SPECIALIZED SERVICES (PASARR/MI)

The purpose of this section is to identify the minimum data needs and process requirements for DMHMRSAS, which is responsible for determining whether the applicant or resident with MI needs a Specialized Services program for mental illness.

Minimum data collected must include:

- A comprehensive history and physical examination of the person: If the history and physical examination are not performed by a Physician, then a Physician must review and concur with the conclusions. The following areas must be included (if not previously addressed): a complete medical history; review of all body systems; specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; and, in case of abnormal findings which are the basis for a Nursing Facility placement, additional evaluations conducted by appropriate specialists;

- A comprehensive drug history, including current or immediate past use of medications, that could mask symptoms or mimic mental illness;

- A psychosocial evaluation of the person, including current living arrangements and medical and support systems;

- A comprehensive psychiatric evaluation including a complete psychiatric history, evaluation of intellectual functioning, memory functioning, orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, degree-of-reality testing (presence and content of delusions), and hallucinations; and

- A functional assessment of the individual's ability to engage in ADLs and the level of support that would be needed to assist the individual with performing these activities while living in the community. The assessment must determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that Nursing Facility placement is required. The functional assessment must address the following areas: self-monitoring of health status; self-administering or scheduling of medical treatment, including medication compliance; self-monitoring of nutritional status; handling money; dressing appropriately; and grooming.

Evaluators may use relevant evaluative data obtained prior to the initiation of the PAS or annual resident review if the data is considered valid, accurate, and reflects the current functional status of the individual. Based on the data compiled, a qualified mental health professional (QMHP) must validate the diagnosis of mental illness and determine whether a program of Psychiatric Specialized Services is needed. In Virginia, a QMHP refers to a Clinician in the health profession, trained and experienced in providing Psychiatric or Mental Health Services to individuals who have a psychiatric diagnosis. Authorized professionals and minimal qualifications that constitute a QMHP are as follows:

- Physician: A Physician of medicine or osteopathy licensed in Virginia;

- Psychiatrist: A Physician of medicine or osteopathy, specializing in Psychiatry and licensed in the Commonwealth of Virginia;

- Psychologist: An individual with a master's degree in Psychology from an accredited college or university with at least one year of clinical experience;

- Social Worker: An individual with a master's or bachelor's degree from a school of social work accredited or approved by the Council on Social Work Education with at least one year of clinical experience;

- Registered Nurse: A Registered Nurse (RN) licensed in the Commonwealth of Virginia with at least one year of clinical experience; and

- Mental Health Worker: An individual with professional education, training, or a degree, or both, in human services or a related field from an accredited college deemed equivalent to those described above with at least one year of clinical experience providing direct services to persons with a diagnosis of mental illness.

EVALUATING WHETHER AN INDIVIDUAL WITH MENTAL RETARDATION REQUIRES SPECIALIZED SERVICES (PASARR/MR)

The purpose of this section is to identify the minimum data needs and process requirements for DMHMRSAS to determine whether or not the applicant or resident with MR needs a continuous Specialized Services program. Minimum data collected must include the individual's comprehensive history and physical examination results to identify the following Nursing Facility information or, in the absence of data, must include Nursing Facility information that permits a reviewer specifically to assess:

- The individual's medical problems;
- The level of impact these problems have on the individual's independent functioning;
- All current medications used by the individual, and the current response of the individual to any prescribed medications in the following drug groups: hypnotics, anti-psychotics (neuroleptics), mood stabilizers and antidepressants, anti-anxiety-sedative agents, and anti-Parkinsonian agents;
- Self-monitoring of health status;
- Self-administering and scheduling of medical treatments;
- Self-monitoring of nutritional status;
- Self-help development such as toileting, dressing, grooming, and eating;
- Sensory-motor development, such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, hand-eye coordination, and the extent to which prosthetic, orthotic, corrective, or mechanical supportive devices can improve the individual's functional capacity;
- Speech and language (communication) development, such as expressive language (verbal and non-verbal), receptive language (verbal and non-verbal), the extent to which non-oral communication systems can improve the individual's functional capacity, auditory functioning, and the extent to which amplification devices (e.g., hearing aids) or a program of amplification can improve the individual's functional capacity;
- Social development, such as interpersonal skills, recreation/leisure skills, and relationships with others;
- Academic or educational development, including functional learning skills;
- Independent living development such as meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bed-making, care of clothing, and orientation skills (for individuals with visual impairments);

- Vocational development, including present vocational skills;

- Affective development such as interests and skills involved with expressing emotions, making judgments, and making independent decisions; and

- The presence of identifiable, maladaptive, or inappropriate behaviors of the individual based on systematic observation (including, but not limited to, the frequency and intensity of identified maladaptive or inappropriate behaviors).

Evaluators may use relevant evaluative data obtained prior to the initiation of the PAS or annual Resident Review if the data is considered valid, accurate, and reflects the current functional status of the individual. The state must ensure that a licensed Psychologist identifies the intellectual functioning measurement of individuals with MR/RC. Based on the data compiled, the state MRA must validate that the individual has MR/RC and must determine whether Specialized Services for MR/RC are needed. In making this determination, the state MRA must make a qualitative judgment about the extent to which the individual's status reflects, singly and collectively, the characteristics commonly associated with the need for Specialized Services, including:

- Inability to take care of most personal care needs; understand simple commands; communicate basic needs and wants; be employed at a productive wage level without systematic long-term supervision or support; learn new skills without aggressive and consistent training; apply skills learned in a training situation to other environments or settings without aggressive and consistent training; demonstrate behavior appropriate to the time, situation, or place without direct supervision; and make decisions requiring informed consent without extreme difficulty;

- Demonstration of severe maladaptive behavior(s) that places the individual or others in jeopardy to health and safety; and

- Presence of other skill deficits or specialized training needs that necessitate the availability of trained MR personnel, 24 hours per day, to teach the individual functional skills.

APPEALS OF PRE-ADMISSION SCREENING AND RESIDENT REVIEW

DMHMRSAS will notify the Nursing Facility promptly as to whether the individual, who was determined to need a Level II assessment, may be admitted to the Nursing Facility. The Nursing Facility must inform the individual of the decision, indicating the reasons for acceptance or denial. Any individual, regardless of method of payment, who wishes to appeal the decision of the Level II assessment or of the resident review process, may do so by sending written notification of such a request to the following:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

This appeal request must be made within 30 days of the resident's notification of the decision. Level I decisions cannot be appealed.

APPEALS OF NOTICE OF INTENT TO TRANSFER OR DISCHARGE

DMAS is the state agency designated by CMS (Center for Medicare and Medicaid Services) to provide fair hearings for residents of certified nursing facilities when a Nursing Facility gives the resident or his/her representative notice of intent to transfer or discharge the resident. DMAS will conduct fair hearings for all residents who appeal regardless of the source of their payment for Nursing Facility Care (Medicare, Medicaid, or private pay). The notice given residents must advise the resident, or his/her representative, that he/she has the right to appeal and should inform the resident that his/her request to appeal must be made to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Federal regulations define a discharge as movement from an entity that participates in Medicare as a skilled Nursing Facility, is a Medicare distinct part, participates in Medicaid as a Nursing Facility, or is a Medicaid-certified distinct part to a non-institutional setting when the discharging facility ceases to be legally responsible for the care of the resident.

A transfer is defined as movement from an entity that participates in Medicare as a skilled Nursing Facility, is a Medicare-certified distinct part, participates in Medicaid as a Nursing Facility, or is a Medicaid-certified distinct part to another institutional setting when the legal responsibility for the welfare of the resident changes from the transferring facility to the receiving facility.

Notices must be given if a resident is to be involuntarily transferred from a certified unit to a non-certified unit within the same facility. Also, notice must be given whenever a resident is transferred from a Medicare-certified Nursing Facility distinct part to a non-Medicare-certified part of a facility.

SPECIAL SCREENING FACTORS

Individuals Transferred from a Nursing Facility to a Hospital

PAS Committees in hospitals must perform a Level I screening for individuals admitted to the hospital from nursing facilities if the individual's physical, functional, or medical status has changed, which may affect the individual's meeting criteria for Nursing Facility Services; the individual's need to transfer to Community-Based Care; or the individual's need for Specialized Care in the Nursing Facility.

For individuals with a diagnosis, history, or presenting evidence of MI/MR/RC, there is no need for a second Level II screening unless the individual's mental health status has changed. The PAS Committee, when completing a second Level I screening on an individual with a condition of MI/MR/RC, must note on the MI/MR Supplement that there has been no change in that

individual's mental status since the previous Level II assessment and, therefore, the assessment continues to be valid.

If an individual is admitted to a hospital from a Nursing Facility, and the individual's condition has not changed according to the above criteria, but placement in a different Nursing Facility is sought, a PAS is not required. The receiving Nursing Facility must complete the necessary documentation for Medicaid admission certification.

When it is necessary to discharge a Nursing Facility resident into a facility other than the one from which he/she was admitted, it is mandatory to inform the receiving Nursing Facility of the hospital length of stay (admission and discharge dates) and the name and address of the Nursing Facility from which the individual was admitted in order for information to be included on the required Medicaid forms of the receiving Nursing Facility.

Individuals Discharged to the Community from a Hospital While Awaiting Institutional Placement

At times, an individual, who has been assessed by an Acute Care Hospital PAS Committee as appropriate for Nursing Facility Care, will be discharged from the hospital to the community to await a Nursing Facility bed. As the Virginia Medicaid Program is aware of the importance of the continuity of care and the ever-changing medical condition and circumstances of the individual, the Virginia Medicaid Program requires that the Acute Care Hospital Social Worker or Discharge Planner call the Health Department, in the locality where the individual is going post-discharge, and send the original copy of the PAS Assessment Package to the local Health Department.

The PAS Assessment Package includes the UAI, the DMAS-96 form, and the MI/MR Supplement. If the recipient has been in the community 30 days or more when placement becomes available, the local Health Department must determine whether another Level I screening is necessary (no significant changes in the individual's condition or circumstances). The local Health Department will contact the individual or the individual's family to determine the individual's circumstances at that time and to inform the individual or family of the possible need for a second screening prior to the actual Nursing Facility placement.

If the local Health Department determines that another screening is not necessary, a letter indicating such will be sent to the individual or the family. A copy of the letter will be sent to the Nursing Facility where the individual is to be placed. The Health Department will attach the PAS Assessment from the hospital. Under no circumstances should a Nursing Facility admit an individual without this approval letter from the local Health Department.

If the local Health Department determines that another PAS is necessary, another PAS assessment will be done following the usual PAS procedures.

Residents Transferring from a Nursing Facility to a Nursing Facility

Individuals residing in a licensed Nursing Facility and desiring a transfer to another Nursing Facility in Virginia are not required to be screened by local or hospital PAS Committees. However, the Nursing Facility, to which the individual is to be transferred, must complete the

Resident Assessment Instrument (RAI), attach information regarding where the individual resided prior to the present placement, and ensure that a Level I screening has been completed. The facility must not admit any new individual, regardless of the pay status, unless the required Level I and Level II screenings (if necessary) have been completed. The transferring Nursing Facility must forward copies of all screening materials to the admitting Nursing Facility. The receiving Nursing Facility is then responsible for initiating the appropriate documentation for admission certification purposes.

Requirements for Individuals Admitted from Out-Of-State

Individuals who are out-of-state and desire a direct transfer to a Nursing Facility in Virginia must be screened by the admitting Nursing Facility using information provided by the transferring Nursing Facility to determine if they meet the criteria for Nursing Facility placement and for conditions of MI/MR/RC. Local or Hospital PAS Committees are not required to pre-screen out-of-state applicants. If a recipient has a diagnosis of MI/MR/RC, then the Resident Review process can be initiated once in the facility by contacting:

OBRA Consultant
DMHMRSAS
P.O. Box 1797, 10th Floor - Jefferson
Richmond, VA 23218
1-804-371-0360

If the individual is Medicaid-eligible, the Virginia Nursing Facility receiving the resident must request a copy of the PAS completed by the other state prior to the individual's transfer (all states must now complete a screening for conditions of MI/MR/RC and a PAS for nursing criteria as well). The Virginia Nursing Facility will document that the individual meets Nursing Facility criteria (i.e., by completing a MDS 2.0) and proceed with admission of the individual as a Medicaid-eligible Nursing Facility resident according to established procedures. For non-Medicaid individuals, the state, in which the Nursing Facility is located, pays for the review unless the states have mutually agreed to other arrangements. It is the responsibility of the admitting Nursing Facility to obtain the Physician's recommendation for Nursing Facility Care.

Individuals Discharged from a Nursing Facility to Community-Based, Personal Care Services

Residents, who are being discharged to Community-Based Services Care, no longer have to be screened by the PAS Committee. The Nursing Facility must provide the personal care agency with the UAI, DMAS-96 form, and medical record information to determine what services need to be provided. The Nursing Facility must coordinate discharge arrangements prior to the recipient leaving the facility. The Nursing Facility needs to ensure, prior to discharge, that the individual is transitioning to a safe environment, that there is a backup caregiver available, and must assist the individual with locating a provider as part of the discharge plan. It is the responsibility of the personal care agency to complete the DMAS –101A form and to coordinate the completion of the DMAS -101B form by the CSB if required. The Nursing Facility must notify all the appropriate agencies when the discharge takes place.

Individuals Discharged from Nursing Facility to an Assisted Living Facility

The responsibility for the assessment and authorization for individuals who are Nursing Facility residents and could possibly be discharged to an assisted living facility rests with the local PAS Committee in the locality of the Nursing Facility. The Nursing Facility will schedule with the PAS Committee in the locality to complete a screening for any individual who wishes to be discharged to an assisted living facility. The PAS Committee should handle this referral as it would a referral coming from anywhere else in the community, except that a referral for a Level II screening is not necessary unless there has been some change in the individual's condition.

Private Pay Individuals Applying for Nursing Facility Admission

Before a Medicaid-participating Nursing Facility can admit private pay individuals who are MI/MR/RC, these individuals must be screened for Nursing Facility criteria and conditions of MI/MR/RC. The Nursing Facility's admission policy must include a procedure for assessing private pay applicants, including the designation of an individual or committee within the facility to complete the assessment to be used and the instructions to be followed if a Level II screening is indicated.

Individuals Transferred from Woodrow Wilson Rehabilitation Center, Veterans' Administration Hospitals, and Children's Hospital in Richmond to a Nursing Facility

The responsibility for the assessment and authorization of individuals who are residents of Woodrow Wilson Rehabilitation Center rests with the staff of Woodrow Wilson Rehabilitation Center under the contract with the University of Virginia Pre-Admission Screening Committee. Individuals seeking Nursing Facility placement from Children's Hospital in Richmond will be screened and authorized by this facility. The UAI and the MI/MR Supplement will be utilized for these screenings.

Individuals in a Veterans' Administration Medical Center (VAMC), who are applying to enter a Nursing Facility, will be assessed by VAMC staff to determine the need for Nursing Facility Care and to identify any mentally ill or mentally retarded individuals, who require further Level II assessment. The VAMC discharge planning staff will use their own Veterans' Administration Assessment Form, the Community Nursing Facility Care Form, and the MI/MR Supplement for the Level I assessment.

Individuals Transferred from a Military Hospital to a Nursing Facility

For individuals who have a direct transfer from a military hospital to a Nursing Facility, the hospital must provide the Nursing Facility with sufficient information regarding the individual's diagnoses, history, functional status, and care needs for the Nursing Facility staff to determine level of care and appropriateness of placement. The military hospital does not complete the UAI, DMAS-96, or MI/MR Supplement forms. The Nursing Facility must use the information to screen the application just as it would for any non-Medicaid-eligible applicant. The Nursing Facility is responsible for completing and submitting to the Fiscal Agent a completed PIRS (Patient Intensity Rating System) DMAS-80 form for a Medicaid-eligible individual.

Individuals Transferred from Community-Based Care or Personal/Respite Care to a Nursing Facility

When an individual is expected to enter a Nursing Facility directly from Community-Based Care or Personal/Respite Care, a new screening is not required. Authorization for Nursing Facility or EDCD Waiver Services is interchangeable. There is no need to update an existing PAS if the individual is actively receiving services through the EDCD Waiver at the time of admission. The admitting Nursing Facility must receive the UAI, DMAS-96 form, and current medical record information. The Level 1 assessment should be done upon admission to the Nursing Facility. If any applicant is currently receiving services through the EDCD Waiver, the Nursing Facility is responsible for completing a Level I screening once the applicant is admitted into the Nursing Facility. If it is determined that the recipient requires a Level II assessment, then the Nursing Facility must initiate the Resident Review process by contacting:

OBRA Consultant
DMHMRSAS
P.O. Box 1797, 10th Floor - Jefferson
Richmond, VA 23218
1-804-371-0360

PRE-ADMISSION SCREENING

DMAS will authorize payment to the Nursing Facility as of the date the resident is both: (1) eligible for Medicaid and (2) documented to meet criteria for Nursing Facility level of care. Individuals must be screened prior to admission to the Nursing Facility when they are Medicaid-eligible or will become eligible within six months following admission. Section 32.1-330 of the *Code of Virginia* states: "The Department shall require a pre-admission screening of all individuals who, at the time of application for admission to a certified Nursing Facility, are eligible for medical assistance or will become eligible within six months following admission." There are four situations that can occur when nursing facilities request Medicaid reimbursement for Nursing Facility Care. The situations and the DMAS payment procedures for situations are:

1. **Individuals, at the time of admission to the Nursing Facility, are Medicaid-eligible or expect to become Medicaid-eligible within six months of admission, enter from the community or the hospital, and are pre-screened.** DMAS will authorize payment upon admission to the Nursing Facility as of the date the resident is both: (1) eligible for Medicaid, and (2) the PAS indicates that the resident meets Nursing Facility level of care. Example: An individual enters the Nursing Facility on February 23; he/she was screened prior to entry and was found to meet the Nursing Facility level of care as of February 20. He was Medicaid-eligible on admission to the Nursing Facility. DMAS will authorize payment for Nursing Facility Care beginning February 23.

2. **Individuals are admitted with private pay status, remain in that status at least six months, and then become Medicaid eligible.** DMAS will authorize payment to the Nursing Facility as of the date the resident is both: (1) eligible for Medicaid and (2) the Minimum Data Set (MDS 2.0) completed within federal time frames indicates that the resident meets criteria for Nursing Facility level of care. Example: An individual enters the Nursing Facility on February 23. The individual was not screened prior to entry and was in private pay status until September 1. The individual became Medicaid-eligible effective September 1. The individual was found to meet Nursing Facility level of care as of September 1. DMAS will authorize payment for Nursing Facility Care beginning September 1.

3. **Individuals are not screened prior to admission and are not Medicaid-eligible, but become Medicaid-eligible within six months of admission to the Nursing Facility, usually because funds were unexpectedly depleted or the stay was expected to be temporary.** The Nursing Facility must document why the required PAS was not completed, including why Medicaid eligibility within six months was not anticipated at admission. DMAS will authorize payment to the Nursing Facility as of the date the resident is both: (1) eligible for Medicaid and (2) the completed MDS 2.0 indicates that the resident meets criteria for Nursing Facility level of care. Example: An individual enters the Nursing Facility on February 23. The individual was not screened prior to entry but became Medicaid-eligible effective February 23, although the individual was not notified of his/her eligibility until May 15. The individual was found to meet Nursing Facility level of care as of February 23. DMAS will authorize payment for Nursing Facility Care beginning February 23.

4. **Individuals are not screened prior to admission and are Medicaid-eligible at admission.** DMAS will authorize payment to the Nursing Facility beginning on the date that the completed MDS 2.0 and DMAS-80 forms are postmarked to DMAS and both: (1) the resident is eligible for Medicaid and (2) the completed MDS 2.0 indicates that the resident meets Nursing Facility level of care. Example: An individual is admitted to the Nursing Facility on February 23. The individual was not screened prior to admission, but was determined to meet Nursing Facility level of care as of February 23. The Nursing Facility mailed the completed MDS 2.0 and DMAS-80 forms to DMAS on April 20. DMAS will authorize payment for Nursing Facility Care beginning April 20. NOTE: The Nursing Facility cannot bill the resident for services if the services are not covered by Medicaid due to the Nursing Facility's failure to obtain pre-authorization or to perform other required administrative functions.

If the individual was not screened prior to admission (situations 2, 3, and 4 above), the Nursing Facility must submit to DMAS a copy of the completed DMAS-80 (PIRS) form and a letter explaining why the screening was not completed. DMAS will review the forms and determine if Nursing Facility level of care is met. If criteria for Nursing Facility level of care are met and the forms are complete, data entry to enable reimbursement will be completed within thirty (30) days of the receipt of the forms. If the forms are not complete, DMAS will return them for completion, which will delay reimbursement until the completed forms are received.

Send the copy of the completed DMAS-80 (PIRS) form and letter to:

Supervisor, Facility and Home-Based Services Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Virginia Uniform Assessment Instrument (UAI)

The individual's status as an individual in need of Nursing Facility Care is determined by the Physician. The Virginia Uniform Assessment Instrument (UAI) must be completed in its entirety by the Nursing Facility PAS Committee, must reflect the justification for Nursing Facility Services, and must be signed and dated (with the month, day, and year) by the Physician. The UAI is shown at the end of this chapter.

DMAS-95 MI/MR Level I Supplement

The purpose of the MI/MR Supplement is to identify individuals with conditions of MI/MR/RC. PAS Committees complete the form for Medicaid-eligible individuals, and the form must be placed in the residents' records. The Nursing Facility must review this form to ensure that the information is compatible with the information on the UAI and that the reasons for the non-referral to a CSB are based on legitimate reasons discussed earlier in this chapter. The MI/MR Supplement is shown under the "Exhibits" section at the end of this appendix. Nursing facilities may elect to use this form to screen private pay applicants for conditions of MI/MR/RC, though they may use any process which meets the statutory requirements.

DMAS-96 - Pre-Admission Screening Plan

The Pre-Admission Screening Plan (DMAS-96) constitutes pre-authorization for admission by the appropriate PAS Committee of the local Health Department or acute care hospital. A sample DMAS-96 form is shown in the "Exhibits" section at the end of this appendix. Nursing facilities do not complete the DMAS-96 form.

The local or hospital-based PAS Committees are to complete the DMAS-96 form and to attach it to the UAI. If the PAS Committee (community-based or acute-care-based) approves Nursing Facility admission, the PAS Committee will send the originals of the UAI and DMAS-96 forms to the Nursing Facility. The DMAS-96 form serves as the certification for Nursing Facility Services and the pre-authorization for DMAS payment for Nursing Facility Care for financially eligible Medicaid recipients. The UAI and DMAS-96 forms will be forwarded to the Nursing Facility where the individual is to be admitted.

This pre-authorization must be obtained prior to admitting the individual to a Nursing Facility, or Medicaid will not make payment. If the pre-authorization has not been received prior to the anticipated date of admission, the Nursing Facility should contact the appropriate PAS Committee to confirm that screening has been completed and determine whether the individual has been approved for Nursing Facility admission. If the PAS Committee's decision is to approve Nursing Facility admission, the assessment and pre-authorization forms will accompany the individual to the Nursing Facility where the individual is being admitted.

A copy of the DMAS-96 form may be forwarded to the local DSS office as needed for financial eligibility determination. For individuals who have been screened by the PAS Committee, the PAS Committee will send a copy of the DMAS-96 form to the appropriate DSS office. In cases where the Nursing Facility is sending the information, the following information must be supplied by the Nursing Facility: the name of the individual; Social Security Number; whether the individual needs Nursing Facility Care; temporary or permanent placement; the Physician's signature; and the date. This information can be added to the UAI.

Initial Physician Recommendation

A Physician must recommend that the individual requires Nursing Facility Services at the time of admission or at the time the individual applies for Medicaid. The initial PAS Physician Recommendation is valid for an individual until the individual's situation changes.

Individuals, who apply for Medicaid after they are admitted, must be recommended for Nursing Facility Care. The application date is the date the family or responsible party applies for Medicaid, not the date the local DSS office notifies the facility of financial eligibility. It is the responsibility of the Nursing Facility to be aware of individuals seeking Medicaid coverage and the date that the application is made. The MDS 2.0 and PIRS forms must be completed and submitted to DMAS.

Hospitalization and Re-admission to a Nursing Facility

Individuals who are admitted from a Nursing Facility into a hospital and are discharged to the **same** Nursing Facility for Nursing Facility Services, regardless of length of stay, do not need to have a new PAS package submitted unless the individual's physical, functional, or medical status has changed (see the "Special Screening Factors" section in this appendix). The resident's record must be appropriately documented to reflect the hospitalization, but no notification to DMAS is required. If an individual is admitted to a different Nursing Facility following a hospital stay, the new Nursing Facility must follow routine admission procedures.

The Facility and Home-Based Services Unit of DMAS must be notified in writing if a resident changes the primary source of payment from Medicaid to Medicare (and vice versa). For example, the Nursing Facility must notify DMAS when a resident becomes eligible for Medicare as a result of hospitalization or when Medicare days have been exhausted. Acceptable forms of notification include the "Medicare Benefits Exhausted" letter or a copy of the control number letter.